

2011

2011 Report of the Director of Public Health - Social Inequalities in Health in Montreal. Progress to Date

Dr. Margaret Chan

Director General - World Health Organization

World Health Organization

Follow this and additional works at: http://digitalscholarship.tsu.edu/mlcejs_info



Part of the [Public Health Commons](#)

Recommended Citation

Chan, Dr. Margaret and World Health Organization, "2011 Report of the Director of Public Health - Social Inequalities in Health in Montreal. Progress to Date" (2011). *Mickey Leland Center for Environment Justice and Sustainability Information Portal*. Paper 3.
http://digitalscholarship.tsu.edu/mlcejs_info/3

This Article is brought to you for free and open access by the Mickey Leland Center for Environment Justice and Sustainability at Digital Scholarship @ Texas Southern University. It has been accepted for inclusion in Mickey Leland Center for Environment Justice and Sustainability Information Portal by an authorized administrator of Digital Scholarship @ Texas Southern University. For more information, please contact rodriguezam@TSU.EDU.

When health is concerned, equity really is a matter of life and death.

Dr. Margaret Chan, Director-General, World Health Organization

Agence de la santé et des services sociaux de Montréal

2011 Report of the Director of Public Health

SOCIAL INEQUALITIES IN HEALTH IN MONTRÉAL

Progress to Date

Québec 

SYNTHESIS REPORT

Agence de la santé et des services sociaux de Montréal

2011 Report of the Director of Public Health

SOCIAL INEQUALITIES IN HEALTH IN MONTRÉAL

Progress to Date

Agence de la santé
et des services sociaux
de Montréal

Québec 

SYNTHESIS REPORT

Published by
Direction de santé publique
Agence de la santé et des services sociaux de Montréal
1301 Sherbrooke Street East
Montréal, Québec H2L 1M3
Telephone: 514-528-2400
www.dsp.santemontreal.qc.ca

Scientific supervision and coordination
Marie-France Raynault, Léa Roback Research Centre

Research and manuscript development
Marie-France Le Blanc, Marie-France Raynault, Richard Lessard

Planning, research, data processing and analysis
Health surveillance in Montréal sector (SÉSAM)

Analysis and writing

Carl Drouin, Christiane Montpetit, Valérie Jarry,
Martine Comeau

Revision

Emmanuelle St-Arnaud, Sylvie Lavoie

Data production and validation

Edith Bergeron, James Massie, Jean Gratton,
Sadoune Ait Kaci Azzou, Maryam Bazargani,
Maude Couture, Mahamane Ibrahima

SÉSAM would like to acknowledge the contribution
of the Canadian Institute for Health Information's
Canadian Population Health Initiative for the data
on hospitalization in Canadian cities:

- Sadiq Raji
- Mélanie-Josée Davidson

Contributors

Robert Bastien, Élizabeth Bergeron, Lise Bertrand,
Angèle Bilodeau, Danielle Blanchard, Irma Clapperton,
Alain Devost, Mylène Drouin, Michèle A. Dupont,
Jacques Durocher, Louis Jacques, Suzanne Laferrière,
Linda Langlais, Isabelle Laurin, Viviane Leaune,
Marie-Josée Legault, Jean-Frédéric Lévesque, Lydia Martin,
Patrick Morency, Nathalie Paquette, Sophie Paquin,
Stéphane Perron, François Tessier, François Thérien.

Coordination committee

Richard Lessard, Director
Carl Drouin
Marie-France Le Blanc
Michel Mongeon
Christiane Montpetit
Marie-France Raynault
Jo Anne Simard
Terry-Nan Tannenbaum
Isabelle Thérien

We would like to thank our reviewers for their invaluable
contributions:

Daniel Corbeil, CSSS de Bordeaux-Cartierville–St-Laurent

France Émond, Regroupement des comités logement
et associations de locataires du Québec

Pierre J. Hamel, INRS-Urbanisation, Culture et Société

Nicole Jetté, Front commun des personnes assistées
sociales du Québec

Richard Massé, École de santé publique de l'Université
de Montréal

Alain Noël, Centre d'étude sur la pauvreté et l'exclusion
sociale et Université de Montréal

Gilles Rioux, Direction de la diversité sociale, Ville de Montréal

Editor

Jo Anne Simard

Communications

Lise Chabot, Manon Hudson, Isabelle Thérien

Translation

Sylvie Gauthier

Graphic design

Le Zeste Graphique

Editorial consultant

Colette Pilon-Bergman

Photography

Fanie St-Michel, Conscience urbaine

Administrative support

Isabelle Thérien, France Magnan

As part of this report, a group of community organizations
working in Montréal was invited to participate in a discussion
forum held on 31 May 2011. We wish to thank participants
for their insights on the priority areas for social inequalities in
health in Montréal.

A full version of the report is available on the DSP's Web site
at www.dsp.santemontreal.qc.ca

Version française disponible sur demande

© Direction de santé publique
Agence de la santé et des services sociaux de Montréal
(2011)
All rights reserved

ISBN 978-2-89673-118-3 (printed version)
ISBN 978-2-89673-119-0 (PDF version)
Legal deposit – Bibliothèque et Archive nationales
du Québec, 2011
Legal deposit – Library and Archives Canada, 2011
Price: \$8

A message from the Director

In August 2009, the World Health Organization published the report of the
Commission on Social Determinants of Health. These determinants are defined as
“the circumstances in which people are born, grow up, live, work and age.” Their
health impacts are no longer a subject for debate, as has been documented in
numerous publications from here and abroad.

Education, employment and income levels, quality of the physical environment, and
access to care deeply influence people's health. Social inequalities are reflected
in differences in birth weight, disease incidence and prevalence rates, and risks of
mortality associated with these diseases. They appear to change life expectancy
by several years and affect individuals' and families' life experiences.

In 1998, the Direction de santé publique de Montréal's first annual report noted a
10-year difference between the average life expectancy of men living in disadvan-
taged neighbourhoods compared with those in wealthy areas. Over a decade has
gone by since this first portrait of Montrealers' state of health was published and
it is now time to measure the progress we have made. Therefore, the Director's
2011 report focuses on social inequalities in health.

This synthesis report will help you understand why we chose the theme of social
inequalities in health and the recommendations I have addressed to the different
levels of government. The full report is available at www.dsp.santemontreal.qc.ca.

I hope you enjoy the read.



Richard Lessard m.d.



» Introduction

Social determinants have a profound influence on people's health because they shape "the conditions in which people are born, grow, live, work and age"¹. Level of education, type of employment and income are all examples of social determinants. "Social inequalities in health" refers to systematic gaps in health among individuals based on social class. Differences in birth weight, disease incidence and prevalence rates and associated risks of mortality reflect these inequalities, which can also cause life expectancy to vary by several years.

¹ Commission on Social Determinants of Health (CSDH). 2009. *Closing the gap in a generation: Health equity through action on the social determinants of health. Final Report*. Geneva: WHO.

In 1998, the Direction de santé publique de Montréal's first annual report noted a 10-year difference between the average life expectancy of men living in disadvantaged neighbourhoods and of those in wealthy areas. Over a decade has gone by since this first portrait of Montrealers' state of health was published and it is now time to measure the progress we have made. Therefore, the Director's 2011 report is focused on social inequalities in health.

Progress to Date

The life expectancy of Montrealers has been climbing steadily over the past few decades. Since 1989-1991 men have gained an average of five years and can expect to live to age 78.7; women have gained three years, and in 2006-2008 had a life expectancy of 83.6 years. However, wealthier individuals are clearly at an advantage: there is still almost a six-year difference between the life expectancies of wealthy men and of poor men. When assessed by territory, the disparities are even more striking. For example, in 2006-2008, the life expectancy of residents in the CLSC Hochelaga-Maisonneuve territory was 74.2 years while residents of Saint-Laurent could expect to live 85.0 years, a difference of almost 11 years.

Disabilities generally affect low-income individuals earlier in life. Therefore, in the Pointe-Saint-Charles, des Faubourgs and Hochelaga-Maisonneuve territories, life expectancy in good health is under 60 years for men and below age 65 for women. This situation contrasts with that of Lac-Saint-Louis, one of the wealthiest territories in Montréal, where residents live in good health an average of 11 years longer than in Pointe-Saint-Charles.

In 20 years, mortality rates for all causes have decreased by 23%, from 895 to 690 per 100,000 people. At the same time, we note that death rates by socioeconomic category rise as income declines. Gaps in mortality rates between rich and poor are particularly obvious when it comes to lung cancer, suicide, problems linked to alcohol, and respiratory diseases.

Death before age 75 is considered to be premature. We refer to preventable mortality when death can be prevented through appropriate and timely medical interventions. Similar to other indicators, preventable mortality rates increase as income declines.

The reduction in infant mortality constitutes one of the major health advances that have occurred in most industrialized countries since the early twentieth century. In Montréal, the decline in mortality in children under a year old continues, with the rate dropping significantly since 1989-1991. However, although it has gone down among the richest and poorest people, infant mortality remains higher in the lowest-income category.

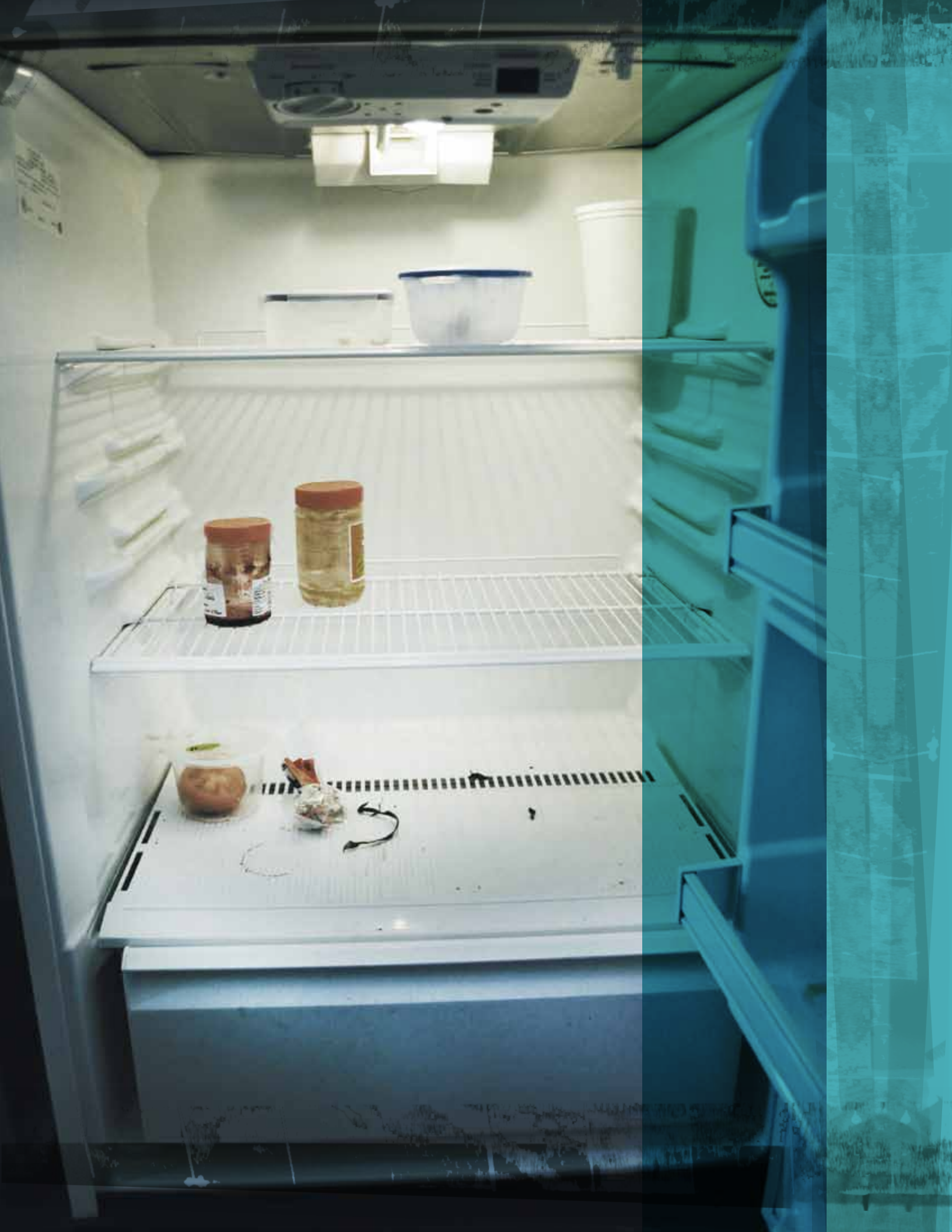
Another revealing statistic: the mortality rate for young people under 20 years of age declined 42% between 1989-1991 and 2006-2008. However, the rate is twice as high in the lowest-income group.

When taking into account life expectancy, disabilities or gaps in mortality, the data prove that social inequalities in health are making people sick and killing them. Nonetheless, because inequalities result from disparities in the distribution of wealth and power, they can be avoided.

How Montréal Compares

Social inequalities in health in Montréal, like elsewhere, are due in large part to income gaps among individuals. The increase in income inequality between wealthy and less wealthy people in Canada has come to the attention of the Organisation for Economic Co-operation and Development (OECD); it has noted that over the past few years, Canadian rates of poverty and inequality have risen more than the average for member countries. In particular, since the end of the 1990s, mechanisms for income redistribution no longer suffice to correct the increase in income inequalities among Canadian households. All age groups are not equally affected since the low-income rate for seniors is about 6% while that for children hovers around 15%.

Policies and incentives to work implemented in Québec in the past few years have focused on improving families' living conditions. Compared with other provinces, Québec has been more successful in reducing social inequalities, as can be seen in after-tax income. In Montréal, however, the poverty rate remains high in comparison with the province as a whole. Currently, although the situation in Montréal is not as



alarming as in Toronto, there have been clear signs of polarization. Montréal has trouble, for instance, keeping well-off families and parents with young children in the city, as do other large Canadian cities.

The evolution of some social determinants that cause social inequalities in health reflects several improvements made in Montréal, especially in relation to income and education. However, some of these gains are offset by losses. While the proportion of university graduates is higher than elsewhere in Québec, the drop-out rate among young Montrealers remains relatively high in comparison with the rest of the province.

Like elsewhere in Québec, people living alone and single-parent families in Montréal are more likely to be living in poverty. The same holds true for other vulnerable groups, which are more numerous in Montréal, and particularly for recent immigrants, who have more difficulty integrating than did their predecessors. The unemployment rate among the latter is 21% whereas it is 8.8% for the rest of the population, in spite of the fact that the university completion rate among immigrants is higher than average.

Compared with five other Canadian cities, the overall health profile of Montrealers offers an interesting study in contrasts. First, Montrealers live longer than residents of Halifax and Winnipeg, but less long than people in Toronto and Vancouver. Also, the picture of lifestyle habits is more nuanced: Montrealers suffer less from obesity and eat more fruit and vegetables, but smoke more.

Moreover, Montréal boasts several enviable statistics that tend to demonstrate the soundness of perinatal and family support policies. Indeed, Montréal does particularly well in the area of child health.

Inequalities by income level observed in Montrealers affect a number of health determinants. However, although the extent of inequalities is worrisome and unjustifiable, health inequalities between rich and poor are often lower in Montréal when compared with other Canadian cities. In most cases, the gaps between the highest and lowest income categories are the smallest or second smallest. In comparison with other Canadian cities, the evolution in Montrealers' income reveals that economic gaps have narrowed. Since health inequalities between wealthy and poor individuals are lower, we can conclude that public policies are effective and efforts made to fight poverty are starting to bear fruit.

A More Just Society

According to the “liberal” criteria espoused since the Age of Enlightenment, there is no justice without equal rights; the degree of fairness by which a society is measured is based on equal opportunity for all, regardless of status at birth.

Some strategies that have been proven to effectively reduce social inequalities in health require interventions from central governments; others are shared responsibilities. Overall, most of these strategies require close collaboration among central and local authorities, public health authorities, stakeholders from the private sector and community groups.

Enough income to live on

In Montréal, despite the progress made to date, many people live below the low-income cutoff point, deal with precarious work conditions and are not sufficiently protected to face downturns in their situations. Among last-resort assistance recipients, people who live alone and childless couples are especially vulnerable. Given that a family of four (two parents and two children) who receive social assistance dispose of \$22,614² annually (while the market basket measure threshold is set at \$28,091) or that a full-time worker paid minimum wage earns about \$16,887, it is not surprising that many households have difficulty paying for essential goods, starting with housing and food.

In particular, for most recipients of social assistance, it is almost mission impossible to have enough to live on and stay healthy, based on current subsistence levels. Considering the negative effects of poverty on health and the fact that health problems often prevent people from finding work and getting out of poverty, do income support programs help people out of poverty or, on the contrary, exacerbate the problem?

2. Includes social assistance, GST credit, the provincial child assistance program and the Canada Child Tax Benefit.

A good start in life

In 2005, there were three times as many low-income families with children aged 0 to 5 years old in Montréal than in the rest of the province. There were twice as many families with young children on social assistance. We know that newborns from low-income families are more exposed than others to risks that can hamper their development and compromise their health. There are, however, two ways to correct social inequalities in health at birth: prenatal care and breastfeeding.

When started early and kept up throughout the pregnancy, prenatal care can have a protective effect and prevent low birth weight, which is associated with being in poorer health than other infants. Screening for potential risks, treating medical problems and counselling for mothers to eliminate contraindicated lifestyle habits and behaviours are all prenatal interventions that help reduce perinatal morbidity and mortality.

Among the protective factors, breastfeeding is almost a panacea that compensates for the negative effects of poverty. Analysis of data from the Enquête longitudinale sur le développement des enfants du Québec (ELDEQ) shows that the protective effects of breastfeeding for the first four months of a baby's life last to age six. Moreover, this study of ELDEQ data also teaches us that breastfeeding for six months is enough to reduce the risk of hospitalization for children from low-income families to that for children from wealthier backgrounds, and that this effect lasts up to age six. Children from poorer families are the ones who would benefit the most from two other lesser known benefits associated with breastfeeding: not only does it reduce the probability of children being hyperactive or inattentive, but it also plays a positive role in language acquisition, an area in which children in Montréal are particularly vulnerable, according to surveys on school readiness. Yet, as is the case for hospitalization, breastfeeding counteracts the negative effects of a family's economic status. Unfortunately, aside from immigrant women, the prevalence of breastfeeding tends to decrease along with socioeconomic status.

Development opportunities for all

As early as kindergarten, we can see that children are unequally prepared to start school. Initial learning experiences are predictors of school success, which is associated with occupational and economic integration. Many studies have confirmed the positive effects of attending quality daycare centres on young children's cognitive development. But attendance must start early and be sustained. Yet, families with low incomes or with mothers who have little education generally use daycare services less regularly and often for a limited number of hours, and their children attend the centres at a later age than children from wealthier families.

Improved daycare policies are required to support the development of Montréal's children and to reduce social inequalities in health. Geographic as well as economic accessibility should first and foremost be reviewed. It is also important that all parents feel welcomed.

Occupational health

We know that work is a way to avoid poverty; it is also important for self-esteem and social integration, as long as the person earns enough money to live decently. Work helps prevent health problems linked to difficult socioeconomic conditions, when working conditions are favourable to health. While work can provide satisfaction, it can also make people sick. Conditions linked to the work environment are fertile ground for occupational health inequalities. Exposure to contaminants, biological agents and noise, weight of physical loads, and repetitive movements are all factors that present risks to the physical and mental health of workers.

In Québec, regulations concerning preventive occupational health and safety services apply only to 15 of the 32 economic activity sectors. Yet, illnesses and accidents equally affect workers in sectors not covered by occupational health services. Moreover, despite evolving scientific knowledge, work environment standards seem to be less strict in this province. Here are a few examples: The level of exposure to chrysotile asbestos tolerated in Québec is 10 times higher than in Ontario, the United States and France, which is 100 times higher than in the Netherlands and Switzerland. Québec also has the highest threshold exposure level in Canada for carbon monoxide.

Carcinogenic substances present another major risk factor for workers since the diseases they can cause are often fatal. Young people aged 15 to 24, often overrepresented in the worst jobs, are exposed to diesel, polycyclic aromatic hydrocarbons, benzene and wood dust, among other potential carcinogenic substances. Young female workers exposed to organic solvents and chemical products before their mid-thirties have a threefold higher risk of developing breast cancer once they reach menopause age.

The dilemma is to try to earn a living without ruining your health. The answer: Improve working conditions.

Access to services

A number of inferences concerning primary care experiences and reduction of social inequalities in health can be drawn from a 2005 study of accessibility and continuity of primary care services in Montréal and Montérégie. The study reveals difficulties newcomers have in accessing services; few of these individuals have family doctors and their many care and services needs are often unmet, when it comes to information or access to care. Moreover, the proportion of individuals who felt they needed to see a doctor but did not do so points to a decreasing gradient: the experiences of Montrealers from deprived areas are less positive, in terms of accessibility and continuity of care, than those of wealthier people.

Preventable mortality rates, that is, the number of deaths that occur despite the existence of care and treatment considered to be effective, is a recognized indicator for measuring access to care. Gaps observed in preventable mortality rates by income quintiles can, in all likelihood, be attributed to unequal access to services. Some vulnerable groups are thus more likely than others not to receive appropriate care for their state of health.

Migrants without permanent legal status are also likely to develop health problems and to have more limited access to care. In the immigration system, various legal statuses determine access to services; this leads to delays in medical visits and treatment, and often causes a sick person's health to worsen. Among the difficulties that contribute to jeopardizing their health are the following: no pre- and post-natal follow-up, low daycare attendance rate, inadequate housing, and difficult living and working conditions. The situation is even worse for undocumented migrants, whose health often declines after arriving in Canada.

Aboriginals, whose presence in Montréal has been growing for the past few years, live in similar situations. In urban environments, Aboriginals do not have access to services they had in their home communities. Without community support, the shock of the transition increases their vulnerability. Paradoxically, while some Aboriginals leave their communities to pursue their studies or look for work, many others are forced to leave because of housing shortages or for health reasons, if they require specialized care. Cultural differences combined with communication barriers hinder their attempts to navigate through the health system, as is the case for immigrants. Consequently, Aboriginal people who move to the city often have limited access to health services.

In the area of sexually transmitted and blood-borne infections, social inequalities lead to increased vulnerability. Injection drug users, men who have sex with men, and street youth are more likely to be exposed to HIV and hepatitis C than other people. Various psychosocial factors (isolation, social exclusion, poor self-esteem, prejudices and stigmatization) foster risk-taking. For some, marginal living conditions, mental health problems, homelessness or drug and alcohol addiction hamper adoption of safe behaviours as well as access to health services adapted to their needs. As a result, many people do not know that they are infected, which delays medical follow-up and contributes to morbidity.

Breast cancer is another good example of mortality linked to social inequalities. In developed countries in particular, the cancer incidence rate for women from disadvantaged areas is lower than for women from high-income neighbourhoods. However, the mortality rate due to breast cancer is equal or even higher than the rate for women from high-income areas, most likely because they are screened later. In Montréal, a survey identified the territories where fewer women participate in Québec's breast cancer screening program (PQDCS). It revealed that, depending on the territory, being an immigrant or having a low income and a low educational level are risk factors associated with lower participation in the PQDCS.

Health care and prevention intended for young children are other examples of how difficult it is for the health system to reach everyone. Children in disadvantaged neighbourhoods see fewer paediatricians and other specialists than children in wealthier areas, but go to emergency departments and are hospitalized more often than children in higher income areas.

Dental care and psychotherapy are two other areas where seeing a health professional is determined by an individual's socioeconomic level. Multiple factors have an impact on dental hygiene and access to care, and there are considerable disparities between people on social assistance or low-income workers and the rest of the population. A recent study showed that a child's risk of having cavities increases by 112% if he or she has lived since birth in a family at the bottom of the social hierarchy. Moreover, poor social standing and having an immigrant mother are two factors linked with a high probability of not seeing a dentist before age four.

In Québec, dental care is rarely covered by the provincial health insurance plan. The cost of dental care and frequent lack of private insurance help explain why people from low-income areas or the working poor rarely seek preventive care and only make appointments to see a dentist when they have a problem or experience pain. The Québec survey confirms the existence of an education and income gradient relative to perception of dental health. Despite having good dental coverage, income security recipients are particularly hesitant about going to the dentist for preventive care.

Access to psychotherapy is equally problematic. The public health care system generally manages severe mental illnesses such as schizophrenia, but not anxiety disorders and reactive depression. Private psychotherapists are too expensive for people without sufficient income or with no private health insurance.

Despite its universal character, the health system leaves many people behind. As is the case for childcare and breast cancer screening, free health care does not eradicate social inequalities in health. And that is not all. When it comes to services that are usually not insured, such as dental care or psychotherapy, access is also reduced for many workers, social assistance recipients or low-income retirees. When the subject of health care privatization is raised in our society, decision makers from the health system must keep in mind the major issues linked to social inequalities in health before making access to care more complicated for the poorest people. Fees would likely divert the health system away from its main mission: to look after people who are sick and protect them from the financial risks that health services not covered by the universal program would represent.

A City for Everyone

Sustainable urban development is intrinsically linked to the issue of population health and depends on the combined efforts of government and civil society to ensure quality of life and social cohesion in large cities. Several elements likely to uphold such cohesion—despite the growing diversity of the population—depend on choices made locally, in particular as regards issues of housing, food safety, security and urban planning. Urban and built environments greatly influence living conditions and, consequently, population health.

Housing

In Montréal, a shortage of rental units, especially large apartments, has resulted in sustained rent increases of nearly 29% since 2000. Currently, 22,000 households are on the Office municipal d'habitation de Montréal's waiting list. For most poor households, when the share of income spent on rent is too high, other needs must be put aside, which can have very negative health impacts.

Given the lack of affordable housing, even the most substandard dwellings find renters. Each year in Montréal, many home inspections are requested by physicians who suspect that conditions in a home are the cause of clinical problems. An epidemiological study of the health of almost 8,000 children confirms that humidity and mould are among the main risk factors for respiratory infections. What is more, various mental health disorders such as stress, depression and anxiety can be associated with poor housing conditions and the presence of vermin in homes. To successfully deal with infestations or unsanitary conditions requires that owners take rapid action to have the required work done, and this involves the close collaboration of tenants, owners, exterminators and municipal authorities. The role of the latter becomes even more important when owners delay taking action.

Nutrition and people with low income

Food supply influences consumption of healthy foods, but geographical access does not explain everything. In 2010, the number of people turning to food banks rose by 22%. Each month, more than 140,000 Montrealers depend on these banks for food. For low-income individuals, cost is an essential determinant of access to healthy foods. It is undeniable: fruit and vegetable consumption varies by income category, and among people whose household income is below \$20,000 a year, only 19% eat five portions of fruit and vegetables a day. This figure is much lower than for all other income categories. Again, we see a social gradient in diet as we do in other areas.

When a large part of income is spent on rent, the food budget of low-income families is even more limited. The result is food insecurity, which can lead to hardship for parents and their children. According to a survey conducted by the DSP, 17% of the population in Montréal reported food insecurity.



Motor vehicle traffic and social inequalities in health

Living close to major transportation arteries generates more risks, especially related to air quality and safety of travel. Both of these health determinants are linked to motor vehicle traffic, an issue upon which we can act on a local level. Poor air quality increases the number of hospitalizations and deaths due to chronic diseases, especially respiratory diseases. From 1999 to 2008, over 9,000 pedestrians were injured in traffic accidents in Montréal, a problem that is not limited to a few intersections. However, the contrast is striking between street and artery design in wealthier boroughs and those in other Montréal neighbourhoods, where motor vehicles take precedence over pedestrians and cyclists. Older neighbourhoods are, of course, more densely populated than newer ones. However, the difference in the number of accidents that occur is striking and traffic volume alone does not account for this discrepancy. In wealthier neighbourhoods, the design principles chosen locally contribute to a greater extent to the security of pedestrians and cyclists.

Access to public transit is another critical issue for low-income citizens. In Montréal, the number of households who do not have cars varies by socioeconomic status: only 21.7% of individuals in the most advantaged quintile do not have cars compared with 40.2% of those in the least advantaged quintile. Considering that low-income individuals more often do not have cars, it is vital that they have access to jobs by public transportation. Moreover, many residents have difficulty getting around within their own neighbourhoods because of inadequate bus service. The cost of transportation is another factor that limits access to public transport.

Neighbourhood design

Physical and social environments influence the health of the population, and neighbourhood design can play a determining role. Of course, the neighbourhood is not the only factor that matters, but people who are confined to it attach a great deal of importance to their immediate environment, especially individuals with reduced mobility. This is the case for older people, children and disabled people. In disadvantaged areas, the neighbourhood is where they find most of the resources they need.

Social inequalities in health are also linked to urban design, which determines access to parks. Proximity to a park, natural area or sport facility strongly influences the practice of physical and sport activities. This is particularly true for families who have small children, are confined to the neighbourhood and cannot afford to pay to access privately-owned facilities. A study has shown that children living in neighbourhoods with more parks report higher levels of physical activity than other children. Moreover, the probability that these children walk to school or simply for leisure is 50% higher in environments conducive to walking.

Urban heat islands are another area where urban environment and design can have determining roles. The issue of urban heat islands, which is linked to global warming, is a new source of concern for public health authorities. In summer in the city, the temperature is a few degrees lower on average in Montréal's greener neighbourhoods than in the more densely populated ones in the downtown area. A study has shown that mortality rates start to rise when the temperature reaches 26°C and then climb significantly starting at 33°C. People at highest risk during heat waves are older or obese individuals, people with chronic diseases, mental illnesses or disabilities, those who are physically active, infants and young children under the age of four, and people who live in substandard housing.

Dwellings located next to highways are especially problematic. For instance, not only are residents living next to the Metropolitan Expressway, an urban heat island, subjected year-round to more noise and air pollution than elsewhere in the city, they also see the situation worsen during heat waves. To improve the well-being of urban populations, especially disadvantaged groups, it is advisable to work toward better urban planning. Harvey Mead, ex-commissioner for sustainable development for Québec, stated that poor development and planning choices enhance the negative effects on urban populations, particularly on disadvantaged groups. Conversely, good choices—those directed toward well-being—are more effective in terms of public expenditures and often more conducive to economic development than policies and programs designed to stimulate progress, business or industry. Several ongoing projects in Montréal, such as integrated urban revitalization and sustainable development projects (e.g. Agenda 21), as well as many other initiatives designed to improve access to healthy choices are putting Montréal on the right track.



» Conclusion and Recommendations

Mixed Results

We conclude with an encouraging observation: the life expectancy of Montrealers is longer now and the overall mortality rate has declined significantly over the past 20 years. Unfortunately, with a few exceptions, health disparities between rich and poor persist and there are still significant differences in health and mortality among the territories of the island of Montréal.

These inequalities, socially produced and therefore avoidable and unjust, influence health throughout life: low birth weight, premature mortality, accidental death among youth and numerous chronic health problems.

In Montréal, there are many vulnerable groups—including older people, low-income households, people living alone, immigrants and Aboriginal people—and their proportions are higher than in the rest of the province. Montrealers' incomes are lower than the average for residents of other Canadian cities. Consequently, we could expect even more glaring health inequalities than in other cities. Yet, the situation is more nuanced than we thought: life expectancy for men and women is comparable to that for residents in other cities, as is the rate for low birth weight. Montrealers are more likely to suffer from diabetes and have more sedentary leisure activities; conversely, they have fewer health-related activity limitations and eat more fruit and vegetables. Moreover, infant mortality and premature births are less common. Of note: a comparison with other Canadian cities, based on survey and hospitalization data, demonstrates that there are often fewer health inequalities between rich and poor in Montréal.

The mixed results reflect, on one hand, growing income inequality in Canada and, on the other, the positive effects of Québec's social policies, particularly those related to families. These social investments are starting to pay off. There is reason to suppose that all of Québec society would benefit from additional actions to counter exclusion and diminish the suffering of poor people, and to ensure they can participate fully in Québec's sustainable development.

>> The public health department's interventions

In Montréal, the Direction de santé publique (DSP) implements several programs on the island that are likely to reduce social inequalities in health at all stages of life.

The DSP intervenes with vulnerable pregnant women through Integrated Perinatal and Early Childhood Services (SIPPE) programs, and actively promotes breastfeeding. Its primary vaccination programs are aimed at all young children in care settings on its territory.

More recently, the DSP has focused on preparing children for school by organizing summits on school readiness. The summits have led to intersectoral and community projects as well as to new research initiatives to better adapt public health interventions.

The DSP shows concern for more vulnerable groups by adapting its practices to various clienteles, such as patients with tuberculosis, injection drug users or homeless youth. A number of professionals at the DSP are also interested in clinical preventive services and critically examine the equitable nature of the care and services offered to the population.

The DSP's occupational health interventions favour early cancer prevention among the most vulnerable workers. It has also developed clinical expertise in this field that enables it to identify harmful exposures and advocate for fair compensation for exposed workers.

Working in conjunction with the Institut national de santé publique, the DSP has put together a research team that examines equity of access to primary care resources. The work of this team has prompted Québec's Health and Welfare Commissioner to recommend stronger measures to make health care coverage more equitable. For almost 10 years now, the DSP has also housed the Léa Roback Research Centre on Social Inequalities in Health. The Centre evaluates best interventions to reduce social inequalities in health.

Through its Urban Environment and Health sector, the DSP is pursuing several targets for improvement of living conditions, including the availability of affordable and nutritious food; improvement of inadequate housing; elimination of heat islands; identification of risks of injury to pedestrians and cyclists; and evaluation of the health impacts of infrastructure improvement projects. The DSP, along with the City of Montréal and Centraide, funds collaborative intersectoral and community committees in city boroughs.

The DSP is publishing its regional public health plan concurrently with this report. The plan outlines the priorities the department plans to carry out with its regional partners, including the 12 health and social services centres (CSSS). The first priority is to reduce social inequalities in health. However, the Director of public health is very aware that there are limits to the actions he can undertake. He also must ensure that these programs do not themselves create inequalities, as is sometimes the case for screening programs; offering health promotion or prevention programs without giving much thought to reaching the most deprived individuals can widen the gaps. The Director is committed, with **the CSSS and other partners, to making preventive services accessible to all and ensuring these services are used by all segments of the population. In this regard, implementing conditions to encourage breastfeeding is a priority because not only is this practice effective, it can also reduce social inequalities in health and have an impact over the long term.**

As such, the Director is calling on all stakeholders to collaborate to reduce social inequalities in health. He is appealing to the provincial and federal governments, who are responsible for broad social protection policies. He is also inviting cities on the island of Montréal, particularly the City of Montréal, to better coordinate their actions with those of the DSP so as to improve the health of all citizens. For ethical, civic and economic reasons (in this era of knowledge economy), the DSP and its municipal partners cannot simply leave a third of Montrealers behind. Health is an invaluable asset to which all citizens have a right. It fosters full participation in a region's community life and economic activities. In this sense, it benefits the entire community as well as each of its constituents.

Recommendations to Reduce Health Inequalities

As Sir Michael Marmot stated in his report as President of WHO's Commission on Social Determinants of Health, we can close the gap in social inequalities in health in a generation by tackling the inequitable distribution of power, money and resources, and by improving poorer people's daily living conditions.

All levels of government are involved in reducing social inequalities. They have the power to set forth and apply policies that support increased incomes, democratization of education, building and renovation of social housing, as well as delivery of preventive and curative social and health services. In this spirit, the Director addresses the first 6 recommendations to the Québec and Canadian governments; the latter's role is to support provincial governments through social transfers. He highlights the importance of broad housing policies and recognizes that the City of Montréal and other municipalities on the island are primarily concerned with improving Montrealers' living conditions, particularly through integrated urban revitalization initiatives. Therefore, the last four recommendations are directed to municipal authorities in particular.

Recommendation 1: Improve the incomes of the poorest people

Forty years ago, Canada committed to reducing poverty among older people. Its success was acknowledged by international organizations such as OECD. However, over the past few years, the OECD has noted an increase of inequalities in Canada.

Households with incomes below the market basket measure threshold face significant health risks: it has been demonstrated that these families cannot devote an appropriate share of their budget to healthy foods. In most cases, the cause is not lack of knowledge about nutrition (which could be remedied by a health education program) but rather lack of money, as evidenced by the dramatic increase in use of food banks in Montréal. The Director of public health is favourable to the principles put forward in the Plan gouvernemental pour la solidarité et l'inclusion sociale 2010-2015, and salutes the provincial government's recent

efforts to improve the lot of single-parent families. The measures put forward should be renewed and enhanced. The Director insists on **the importance of increasing welfare rates, especially for people living alone considered employable**. Scale rates for last-resort benefits are clearly inadequate when compared with the market basket measure threshold, and recipients' health is endangered because they lack the resources to stay healthy.

» **Recommendation 2:**
Increase access to government-funded early childhood centres (CPE) in low-income neighbourhoods

The OECD has emphasized Québec's efforts to implement redistributive measures related to family policy, in particular the reduced-contribution daycare program. Indeed, these childcare centres are one area in which Québec stands out from the rest of Canada, which lags behind significantly in terms of early childhood services. These universal measures, which also target gender equity, are similar to those in Nordic countries, who come out on top every year in the fight against poverty. CPE have proven not only to increase the number of women in the labour force in Québec—which helps increase family incomes—but also to reduce social inequalities in child development. Given the decline in the share of government-run childcare centres in relation to the overall number of daycare centres in Montréal, **the Director of public health recommends that various levels of government increase the geographical access and number of places in government-funded childcare centres in deprived neighbourhoods and broaden the economic accessibility of low-income families. He also recommends that we seek to enhance understanding of the main determinants for childcare attendance by low-income children.**

» **Recommendation 3:**
Increase funding for social and community housing and ensure that the mechanisms used to set housing rental rates are rigorous and effective

Since the first annual report on social inequalities in health was published in 1998, the price of housing has continually risen in Montréal. A majority of low-income households do not benefit from subsidized housing and must deal with the price of rents in the private market. The growing portion of a household's budget required for rent means that there is less left over for other essential needs, with food being at the top of the list. **The Director recommends that funding for social and community housing be increased and that mechanisms used to set housing rental rates be rigorous and effective.**



»» **Recommendation 4:**
Maintain and develop
the public health care system

The growing role of the private sector in the area of health is a constant concern, and for good reason. We note that while in general, deprived individuals and immigrants have less positive experiences with the public health system, the situation is more dramatic when they must use the largely private system, as is the case for psychotherapy and dental care. **The Director recommends that free and universal access to the health system be preserved, and that measures to develop the health system be taken, while bearing in mind the health problems affecting the poorest individuals.**

»» **Recommendation 5:**
Develop services and programs
to better integrate immigrants

Since the 1990s, we have witnessed a demographic change in Montréal and many immigrants have found it difficult to integrate the job market. Services and programs must be adapted to these new needs, whether by improving recognition of qualifications—for prior training and previous work experience—or by upgrading services. Labour market integration is essential for successful and harmonious immigration. **The Director recommends that adapted services and programs be developed to better integrate immigrants and reduce their poverty.**

»» **Recommendation 6:**
Invest in public transport
and make it more affordable

Deprived populations are more confined to their neighbourhoods and own fewer cars. Despite this situation, they are more likely to be subjected to the negative impacts of traffic volume (road accidents and poor outdoor air quality). It is imperative that public transport be developed. But it is especially important to do so for people at the bottom of the economic ladder, who depend on public transport to travel to work and participate fully in the community. **The Director recommends adding resources to improve the effectiveness of the public transit system so as to better serve all neighbourhoods, and to make public transport more affordable.**

»» **Recommendation 7:**
Introduce a process to evaluate
the impacts on social inequalities

Cities have levers they can use to reduce social inequalities in health, such as policies on sport and recreation, administration of last-resort programs and development plans. The City of Montréal is already pursuing a policy of sustainable development that should include social development, a component of which is equality. **The Director recommends the following: Similar to what the provincial government has been doing in the area of health since the adoption of Section 54 of the *Public Health Act* in 2001, introduce a process to evaluate the impacts on social inequalities of regulations and projects discussed by borough councils, the City of Montréal's municipal council, Montréal's metropolitan community council and the agglomeration council.**

» Recommendation 8: Support collaborative intersectoral committees and community groups

Society is complex and the exercise of citizen power often comes up against a brick wall. Legal and administrative processes that govern society make it difficult for anyone other than large corporations or institutions to have their voices heard. To foster a better understanding of citizens' needs and to enhance collaboration with elected officials towards improving neighbourhoods, **the DSP has been working with the City of Montréal and Centraide for several years to support collaborative committees in city neighbourhoods, especially in the most deprived areas. The Director recommends pursuing this initiative to foster democratic participation and invites his partners to maintain this alliance and enhance their support to community groups working to improve the living conditions and defend the rights of the most disadvantaged individuals.**

» Recommendation 9: Encourage active transportation and ensure users' safety

Poorer downtown neighbourhoods are disproportionately affected by traffic accidents involving pedestrians. **The Director encourages the City of Montréal to systematize traffic calming measures and active transportation safety (walking, cycling) interventions.**

» Recommendation 10: Ensure adequate and accessible housing

Quality of daily life often goes hand in hand with quality of housing, that is, healthy housing and the space required for residents to have healthy, non-stressful interactions. Not all cities on the island of Montréal participate as much as they could in social housing programs; some do not have such programs. **The Director recommends the development of more healthy, affordable, accessible and well-located housing, as well as building units that are large enough to meet the needs of families.**

Disadvantaged individuals, particularly recent immigrants and those seeking refugee status, are more likely to live in Montréal's substandard housing and are often less well prepared to advocate for their rights. **The Director recommends that inspection and complaint processes be reviewed and bolstered to deal with unhealthy housing conditions.**



Social injustice sickens and kills. Yet, social inequalities in health are avoidable as long as all levels of government join forces. That is why the Director of public health's recommendations are intended mostly for these bodies. Moreover, several sectors of society must be mobilized to implement new practices and policies for the poorest individuals. This supports ongoing discussions within community organizations and requires the collaboration of the corporate sector. Above all, combating social inequalities in health involves the commitment of all Montrealers. Not only must they recognize injustices, they must also support preventive and remedial actions taken by governments.



Recommendations

The Director of public health undertakes and invites his partners from the health network

- to make preventive services accessible to all and ensure these services are used by all segments of the population.

He calls upon the governments of Québec and Canada to

- improve the incomes of the poorest people;
- increase access to government-funded early childhood centres in low-income neighbourhoods;
- increase funding for social and community housing and ensure that the mechanisms used to set housing rental rates are rigorous and effective;
- maintain and develop the public health care system;
- develop services and programs to better integrate immigrants;
- increase the effectiveness of and economic accessibility to public transportation

He calls upon municipal authorities to jointly

- introduce a process to evaluate the impacts on social inequalities;
- support collaborative intersectoral committees and community groups;
- encourage active transportation and ensure users' safety;
- ensure housing is adequate and accessible.

QUANTITY	TITLE OF PUBLICATION (printed version)	UNIT PRICE (includes all charges)	TOTAL
	2011 Report of the Director of Public Health: Social Inequalities in Health in Montréal. Progress to Date. Synthesis Report.	\$8	
	ISBN NUMBER (printed version) 978-2-89673-118-3		

Name

Address

No.

Street

Apt.

City

Province

Postal Code

Telephone

Fax

Orders are payable in advance by cheque or money order made out to the Direction de santé publique de Montréal.

Please mail your order to
Centre de documentation
Direction de santé publique
1301, rue Sherbrooke Est
Montréal (Québec) H2L 1M3

Information: 514-528-2400 ext. 3646



**Agence de la santé
et des services sociaux
de Montréal**

Québec  
 